MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10568

CERTIFICATE OF DEATH

10568

Reg. Dist. No. 1C6

1. PLACE OF DEATH
a. COUNTY Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah
c. LENGTH OF STAY IN 1b 6 m/cs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Pisgah
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Katherine Middle Jean Last Butler

4. DATE OF DEATH Month October Day 28 Year 1957

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 10, 1957
9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months 1 Days 18 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Infant)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Odell D. Butler
14. MOTHER'S MAIDEN NAME Elizabeth M. Bowman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Odell D Butler, Pisgah. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Influenzal — INTERVAL BETWEEN ONSET AND DEATH 4 days
480X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 27, 1957, to Oct 28, 1957, that I last saw the deceased alive on Oct 27, 1957, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Frank A Swan M.D. ADDRESS (Street, city or town, state) Indian Head. Md. DATE SIGNED

PHYSICIAN'S NAME (Type) Frank A Swan M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-28-57
22c. NAME OF CEMETERY OR CREMATORY Smith Chapel
22d. LOCATION (City, town, or county) (State) Pisgah. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS None (Father willbury child)
24a. REC'D BY REGISTRAR DATE NOV 12 1957
24b. REGISTRAR'S SIGNATURE Mabel Lucy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10569

10569

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY Charles. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newport
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE
b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Newport Md.
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First BABY Middle Boy Last DORSEY
4. DATE OF DEATH Month 10 Day 8 Year 1957
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10-8-57
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME James Elmer Dorsey
14. MOTHER'S MAIDEN NAME Geneva Cecilia Rowland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Premature 7 mos. Wt 4#
762.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Atelectasis
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
10-8-57

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE C. J. Edelen M.D.
EXAMINER'S NAME (Type) C. J. EDELEN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED 10-9-57

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF Sept 9-1957
22c. NAME OF CEMETERY OR CREMATORY St Mary's
22d. LOCATION (City, town, or county) (State) Newport Md.

23. FUNERAL DIRECTOR'S SIGNATURE Arehart Inc
ADDRESS Leonardtown Md
24a. REC'D BY REGISTRAR DATE 10/14/57
24b. REGISTRAR'S SIGNATURE Julia M Raney

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

4000299XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10570

10570

CERTIFICATE OF DEATH

Reg. Dist. No. 109

1. PLACE OF DEATH
a. COUNTY Chas MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo La Plata, Md.
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Tyrone Middle: Sylvester Last: Dyson

4. DATE OF DEATH Month: Oct Day: 9/1957 Year: 19

5. SEX male
6. COLOR OR RACE col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10-7-57
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Earle Lee
14. MOTHER'S MAIDEN NAME Mary Elizabeth Dyson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: mother Waring Hill, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH 10-9-57
DUE TO (b) Prematurity 4 3 wks — 10-7-57
DUE TO (c) Dt 2# 8 3/4

762.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-7, 1957, to 10-9, 1957, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE E. Edelen M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED 10-9-57
PHYSICIAN'S NAME (Type) E. J. EDELEN M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-11-57
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart
22d. LOCATION (City, town, or county) (State) Laplata md

23. FUNERAL DIRECTOR'S SIGNATURE Arehart Inc
ADDRESS Laplata md
24a. REC'D BY REGISTRAR DATE 10/4/57
24b. REGISTRAR'S SIGNATURE Julia H Posey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2066192XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10571

Reg. Dist. No. 105

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
c. LENGTH OF STAY IN 1b 10 min

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF DECEASED (Type or print) First DAN Middle Last FAGAN

4. DATE OF DEATH Month 10 Day 11 Year 1957

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 5-24-94

9. AGE (In years last birthday) 63 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motor Mech (Retired)

10b. KIND OF BUSINESS OR INDUSTRY Work New York

11. BIRTHPLACE (State or foreign country) N.J.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Jessie Fagan

14. MOTHER'S MAIDEN NAME Minerva Coulter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 578-46-8050

17. INFORMANT wife Address Cobb Island Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH 10-11-57

022X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. V. Edelen M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED 10-11-57

EXAMINER'S NAME (Type) E. V. EDELEN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10-14-57

22c. NAME OF CEMETERY OR CREMATORY Cedar Hill

22d. LOCATION (City, town, or county) Suitland (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Mehrle Inc. ADDRESS La Plata Md

24a. REC'D BY REGISTRAR DATE 10/14/57

24b. REGISTRAR'S SIGNATURE Julia H Raney

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10572

CERTIFICATE OF DEATH

: 10572

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY: CHARLES — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAPLATA

LENGTH OF STAY (in this place): 10 x

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md. COUNTY: Chas

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Bryans Road.

STREET ADDRESS (If rural give location): 1

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) EMMETT (Last) GARLAND

4. DATE OF DEATH: (Month) Oct (Day) 13 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	W	27 Jan 1882	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Builder	Virginia, Charlottesville	US.

13. FATHER'S NAME: George (?) GARLAND

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-03-7416

17. INFORMANT & ADDRESS: Mrs Mable Garland Jenkins Rural Bryans Road.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
454x IMMEDIATE CAUSE (A)	Respiratory collapse.	12 hrs
ANTECEDENT CAUSE(S) DUE TO (B)	Embolis	2 min
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	Aorta - iliac thrombis	3 days.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	CVA involving left side	3 years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Oct, 1957, to 13 Oct, 1957, that I last saw the deceased alive on 13 Oct, 1957, and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE		ADDRESS (Street, city, town, state)	DATE SIGNED
H Howard	MD M.D.	La Plata. Md.	13 Oct 57.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-15-57	Oakwood	Charlottesville Va

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
10/17/57	Julia H Raney	Herbert Funeral	La Plata Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10573 (Reg. Dist. No. 780)

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laplata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Phy Mem Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Indian Head
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BERTHA Middle ELIZABETH Last HARDY

4. DATE OF DEATH: Month 10 Day 26 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 1-27-1878
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ~~Maryland~~ [illegible]
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William A Johnson
14. MOTHER'S MAIDEN NAME: [illegible] Amanda M. Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs Alexander M Bryan Indian Head Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 10-26-57
331x
DUE TO (b): Hypertension — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Vernon B Dettor M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑ — DATE SIGNED: 29 October 1957
EXAMINER'S NAME (Type): VERNON B. DETTOR, M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 10-29-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Urchart Inc — ADDRESS: Laplata Md
24a. REC'D BY REGISTRAR DATE: 10/31/57
24b. REGISTRAR'S SIGNATURE: Julia H Barry

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10574

CERTIFICATE OF DEATH

Reg. Dist. No. 10574

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rison-Rural
c. LENGTH OF STAY IN 1b: 3-Mths.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: None

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rison- Rural
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Wanda Lee Hart — Middle — Last

4. DATE OF DEATH: Month 10 — Day 23 — Year 57 (19)

5. SEX: Female

6. COLOR OR RACE: Nrgro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-29-57

9. AGE (In years last birthday): 3-Mths

IF UNDER 1 YEAR: Months 2 — Days 24 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): USA

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. Hart

14. MOTHER'S MAIDEN NAME: Ella Dalores Riley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: William H. Hart, (Father) Rison Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia-Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 24-Hours
490 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-18-57, 19____, to 10-23-57, 19____, that I lost saw the deceased alive on 10-23-57, 19____, and that death occurred at 4P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. Andrews M.D. — ADDRESS (Street, city or town, state): Indian Head Md — DATE SIGNED: 10-23-57

PHYSICIAN'S NAME (Type): James E. Andrews-17-Potomac Ave Indian Head Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-25-57

22c. NAME OF CEMETERY OR CREMATORY: Elefunda Church

22d. LOCATION (City, town, or county) (State): Cucamunga Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm H. Hart — ADDRESS: Rison, Md.

24a. REC'D BY REGISTRAR DATE: 10/25/57

24b. REGISTRAR'S SIGNATURE: Mary Swetland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10575

CERTIFICATE OF DEATH

10575

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Physicians Hospit

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Hill Top
d. STREET ADDRESS: Laplata md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CYNTHIA Middle LOUISE Last HEARD

4. DATE OF DEATH: Month Oct Day 29 Year 1957

5. SEX: female
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 24 1954
9. AGE (In years last birthday): 3 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months 8 | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Washington DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Heard
14. MOTHER'S MAIDEN NAME: Roselee Heard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Albert Heard Laplata md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Uremia	3 days
DUE TO (b)	renal failure	3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	toxic dehydration	5 days

517 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): throat infection

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-24 19 57 to 10-29-57 19 ____ that I last saw the deceased alive on 10-29 19 57, and that death occurred at 2:25 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): La Plata Md
DATE SIGNED: 10-29-57
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-31-57
22c. NAME OF CEMETERY OR CREMATORY: Mt Hope
22d. LOCATION (City, town, or county) (State): Ironsides Md

23. FUNERAL DIRECTOR'S SIGNATURE: Chehart Funeral Home
ADDRESS: La Plata Md
24a. REC'D BY REGISTRAR DATE: 10/31/57
24b. REGISTRAR'S SIGNATURE: Julia H Haney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10576

CERTIFICATE OF DEATH

10576

Reg. Dist. No. 100

M

1. PLACE OF DEATH

COUNTY: CHARLES — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
David	Oscar	HOYLE	Oct	13	19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	Married	May 29 1878	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sawmill Labor	Sawmill	North Carolina	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO	None	G. L. Mathis Waldorf Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
442X IMMEDIATE CAUSE (A)	Respiratory Collapse.	1 hr.
ANTECEDENT CAUSE(S) DUE TO (B)	Cardio-vascular-renal disease.	12 years.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	Arteriosclerosis.	10 years.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	CVA	9 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1950, to 13 Oct, 1957, that I last saw the deceased alive on 12 Oct, 1957, and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE	M.D.	ADDRESS (Street, city, town, state)	DATE SIGNED
A Sumwalt		La Plata. Md.	13 Oct 57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, or town, county) (State)
Burial	Oct 15 1957	Elmwood Cemetery	Waynesville N.C.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
10/15/57	Julia H Carey	Hunt Funeral Home	Waldorf Md

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 10577 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10577

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Waldorf
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First THOMAS — Middle B. — Last JEFFERSON

4. DATE OF DEATH: Month 10/26/57 — Day — Year 19

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-16-25

9. AGE (In years last birthday): 32 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Washington, DC

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Jefferson

14. MOTHER'S MAIDEN NAME: Beatrice Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unk
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218 14 3601

17. INFORMANT: Medical Examiner — Address: La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Alcoholism — INTERVAL BETWEEN ONSET AND DEATH:
322.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William V. Lovitt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 10/28/57

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-31-57
22c. NAME OF CEMETERY OR CREMATORY: Mt Zion Meth. Cem.
22d. LOCATION (City, town, or county) (State): Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: The Huntt Funeral Home Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: 10/30/57
24b. REGISTRAR'S SIGNATURE: Julia A Posey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

N24

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10578

10578 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, cremation or removal.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Point, Md.
d. STREET ADDRESS: Charles County
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jennice Middle: Louise Last: King

4. DATE OF DEATH: Month: Oct. Day: 27 Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 2, 1956

9. AGE (In years last birthday): 1 yrs. IF UNDER 1 YEAR: Months: 3 Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Charles Co., Md.

12. CITIZEN OF WHAT COUNTRY? No S.A.

13. FATHER'S NAME: Leroy King

14. MOTHER'S MAIDEN NAME: Helen Smothers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Dehydration — INTERVAL BETWEEN ONSET AND DEATH: 1 day

481 X

DUE TO (b): Influenza — 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E Edelen M.D.

EXAMINER'S NAME (Type): W. J. EDELEN

CHIEF MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 10-27-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-30-57

22c. NAME OF CEMETERY OR CREMATORY: Holy Ghost

22d. LOCATION (City, town, or county) (State): Issue, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Richard Inc ADDRESS: La Plata Md.

24a. REC'D BY REGISTRAR DATE: 10/31/57

24b. REGISTRAR'S SIGNATURE: Julia H Posey

VS. A15ME(5)
SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10579

CERTIFICATE OF DEATH

10579

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Indian Head, Maryland
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Infant — Middle — Last Kuntz

4. DATE OF DEATH: Month October — Day 10 — Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 10/1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — Hours 3 — Min.
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): La Plata, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Larue Kienzle Kuntz

14. MOTHER'S MAIDEN NAME: Katherine Merion Ruth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: mother — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 10-10-57
762.5
DUE TO
(b): Prematurity Wt 2# 6 oz — 10-10-57
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-10, 19 57, to 10-10, 19 57, that I last saw the deceased alive on 10-10, 19 57, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Edelen M.D. — ADDRESS (Street, city or town, state): La Plata, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): E. J. Edelen, M. D La Plata, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10-11-57

22c. NAME OF CEMETERY OR CREMATORY: Lee's

22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Urhart Inc — ADDRESS: La Plata Md.

24a. REC'D BY REGISTRAR DATE: 10/14/57

24b. REGISTRAR'S SIGNATURE: Julia H Posey

2066273 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Item 4, Film G222, 11/1/57 fcy

10580

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10580

CERTIFICATE OF DEATH

Reg. Dist. No. 100

10580

1. PLACE OF DEATH

COUNTY Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laplata md

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Phy mem

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE md COUNTY Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laplata md.

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) VERA (Middle) ALENE (Last) MASON

4. DATE OF DEATH (Month) Oct. (Day) 18, (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	Col		June 29 1957	3 Months		21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Charles co	U.S.a

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel mason	Helen Savoy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
		Samuel Mason

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

571.0 IMMEDIATE CAUSE (A) MYOCARDITIS — INTERVAL BETWEEN ONSET AND DEATH: 10-18-57

ANTECEDENT CAUSE(S) DUE TO (B) AC INF. DIARRHOE — 10-15-57

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-15-57, to 10-18-57, that I last saw the deceased alive on 10-18-57, and that death occurred at 4 AM, from the causes and on the date stated above.

SIGNATURE E. Edelen M.D. M.D. — **ADDRESS** (Street, city, town, state) LAPLATA MD. — **DATE SIGNED** 10-18-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-19-57	Sacred Heart	Laplata md

24. REC'D BY REGISTRAR DATE 10/24/57	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
	Julia T Raney	Orehart Inc	Laplata md

4000182 X 5

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10581

Reg. Dist. No. 100

M

1. PLACE OF DEATH a. COUNTY: Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: 3 hrs 15 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicians Memorial

66

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Pomfret b. COUNTY: Chas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Pomfret
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Archibald Middle: Last: Roby

4. DATE OF DEATH Month: 10 Day: 24 Year: 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 17, 1875
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

1

13. FATHER'S NAME: Somerset Roby
14. MOTHER'S MAIDEN NAME: Georgiana Richards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Glody Kline Address: 2520 14 ave. D.C.

I 0

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

331X

DUE TO (b) Generalized Arteriosclerosis — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No injury
20c. TIME OF INJURY Hour: 1:15 a.m. Month, Day, Year: 24 Oct. 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Pomfret, Charles, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: V B Dettor M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 24 Oct. 1957

2.

EXAMINER'S NAME (Type): V. B. DETTOR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-26-57
22c. NAME OF CEMETERY OR CREMATORY: Congressional
22d. LOCATION (City, town, or county): Washington (State): DC

23. FUNERAL DIRECTOR'S SIGNATURE: Arehart Lee ADDRESS: La Plata Md
24a. REC'D BY REGISTRAR DATE: 10/24/57
24b. REGISTRAR'S SIGNATURE: Julia H. Romy

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10582

CERTIFICATE OF DEATH

Reg. Dist. No. 10583

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hughesville
c. LENGTH OF STAY IN 1b: 5 mo

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hughesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION:

3. NAME OF DECEASED (Type or print): First CYNTHIA Middle LOUISE Last SEWELL

4. DATE OF DEATH: Month Oct. Day 1 Year 1957

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 18, 1957
9. AGE (In years last birthday): 5 mo
IF UNDER 1 YEAR: Months 5 Days 13
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH FRANCIS SEWELL
14. MOTHER'S MAIDEN NAME: THELMA MONROE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: father - Jos. F. Sewell - Hughesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Gastro Enteritis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
571.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 18, 1957, to Oct 1, 1957, that I last saw the deceased alive on Oct 1, 1957, and that death occurred at 3:NP M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Vaheh M. Seron M.D.
ADDRESS (Street, city, or town, state): Aquasco, Md
DATE SIGNED: 10/1/57
PHYSICIAN'S NAME (Type): VAHEH M. SERON MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 2 1957
22c. NAME OF CEMETERY OR CREMATORY: St Mary's
22d. LOCATION (City, town, or county) (State): Bryantown Md

23. FUNERAL DIRECTOR'S SIGNATURE: Hunt Funeral Home
ADDRESS: Waldorf Md
24a. REC'D BY REGISTRAR DATE: 10/5/57
24b. REGISTRAR'S SIGNATURE: Julia H Posey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

4000239 X V2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG222 11-5-57 et

10583

CERTIFICATE OF DEATH

10584

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: Cha rles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pisgah
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pisgah
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William Middle: B. Last: Simmons

4. DATE OF DEATH: Month: Oct Day: 28 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 26, 1867

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Florence Simmons Address: Pisgah, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

442x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Senility — 10 years

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1957 to Oct 28 1957 that I last saw the deceased alive on Oct 12 1957 and that death occurred at 7:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James E Andrews M.D. ADDRESS (Street, city or town, state): Indian Head Md DATE SIGNED: 10-30-57

PHYSICIAN'S NAME (Type): JAMES E. ANDREWS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov 4, 1957

22c. NAME OF CEMETERY OR CREMATORY: St Ignatius

22d. LOCATION (City, town, or county) (State): Hill Top Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hunt Funeral Home Waldorf Md

24a. REC'D BY REGISTRAR DATE: 10/30/57

24b. REGISTRAR'S SIGNATURE: Julia B Haney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10584 **CERTIFICATE OF DEATH** Reg. Dist. No. 10585

1. PLACE OF DEATH
a. COUNTY Charles Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hughesville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rural - Hughesville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle S. Last THOMPSON

4. DATE OF DEATH Month Oct. Day 31, Year 1957

5. SEX MALE

6. COLOR OR RACE NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH ? ? about 90

9. AGE (In years lost birthday) yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT James R. Thompson Address Hughesville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH 1 yr

421.4

DUE TO (b) Valvular Heart Disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19____, to Oct 31, 1957, that I last saw the deceased alive on Oct 30, 1957, and that death occurred at 8:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Vaheh M. Seron M.D. ADDRESS (Street, city or town, state) Cheverly Md DATE SIGNED Nov 1, 1957

PHYSICIAN'S NAME (Type) VAHEH M. SERON MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 11/4/57

22c. NAME OF CEMETERY OR CREMATORY St. Mary's

22d. LOCATION (City, town, or county) (State) Bryantown Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hewitt Funeral Home Waldorf, Md.

24a. REC'D BY REGISTRAR DATE 11/5/57

24b. REGISTRAR'S SIGNATURE Julia W Posey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10585

CERTIFICATE OF DEATH

10586

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CHARLES

b. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAPLATA

c. LENGTH OF STAY IN 1b: 3 days.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL X/ POPES CREEK

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PHYSICIANS MEMORIAL

d. STREET ADDRESS: /

e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First BRUCE Middle MATTHEWS Last WILMER

4. DATE OF DEATH: Month OCTOBER Day 21 Year 1957

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 27, 1883

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pere Wilmer

14. MOTHER'S MAIDEN NAME: Amelia Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Mrs. Bruce Wilmer, Address: Popes Creek Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 3days.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): hypostatic pneumonia, right chest — 4days.

DUE TO (c): C.V.A — 2months.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary occlusion in 1950.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1957, to October, 1957, that I last saw the deceased alive on 21 Oct, 1957, and that death occurred at 5:50 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J.D. Woodley M.D. ADDRESS (Street, city or town, state): La Plata, Maryland. DATE SIGNED: 22 Oct 57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 24 1957

22c. NAME OF CEMETERY OR CREMATORY: Mt. Rest

22d. LOCATION (City, town, or county) (State): La Plata, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Huntt Funeral Home, Waldorf, Md. ADDRESS

24a. REC'D BY REGISTRAR DATE: 10/25/57

24b. REGISTRAR'S SIGNATURE: Julia H. Ramsey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10586

CERTIFICATE OF DEATH

10587

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Waldorf
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: S. — Last: Wilson

4. DATE OF DEATH: Month: Oct. — Day: 27 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 4 1885

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Govt. worker

11. BIRTHPLACE (State or foreign country): Wash. D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel S. Wilson

14. MOTHER'S MAIDEN NAME: Katherine Andrews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: R. Elwood Wilson — Address: Waldorf Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ca. Segmoid — INTERVAL BETWEEN ONSET AND DEATH: 7-26-57
153X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diverticula of Segmoid Emphysema, old Healed TBC

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Deceased

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-3, 1955 to Oct 24, 1957, that I last saw the deceased alive on Oct 24 1957, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. N. Woodridge M.D. — ADDRESS (Street, city or town, state): 3115-16 St N.W. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Wm. N. Woodridge

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 29 1957
22c. NAME OF CEMETERY OR CREMATORY: Congressional
22d. LOCATION (City, town or county): Washington, D.C. (State)

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Huntt Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: 10/30/57

24b. REGISTRAR'S SIGNATURE: Julia H Barry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55